VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

May 24, 2011

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 30, 2011 reflecting the results of the IDR.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 05354

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F 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 03/282011 and 03/30/2011. The following regulatory violations were identified: 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that a comprehensive care plan was developed to address all identified needs for 2 of 15 residents in the applicable sample. (Residents #76 and #27) Findings include:	F 000	Allegation of Substantial Compliance Vernon Green Nursing Home has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
F 279 SS=D		F 279	**F279** The Facility has and continues to ensure that the facility develops/revises and/or reviews care plans as needed. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** 1. A care plan is in place pertaining to the antipsychotic medications with the appropriate measurable objectives specific to the use of that medication and it identifies the specific behavioral issues for which the medication is used to monitor for effectiveness. 2. Resident is deceased.	4/18/11 4/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. Bradford Ellis | Executive Director | May 12, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 1. Per record review, the care plan for Resident #76 did not address use of an antipsychotic medication. A physician order, dated 1/19/11, stated to administer Seroquel (antipsychotic) 50 mg PO (by mouth) daily at 8:00 AM. A subsequent physician order, dated 2/23/11, stated to add Seroquel 25 mg PO at 4:00 PM and HS (bedtime). Although the resident's care plan, dated 1/20/11, identified use of psychotropic medications that indicated use of both an antianxiety and antipsychotic drug, it did not include the name of the antipsychotic drug, lacked measurable objectives specific to the use of the drug and did not identify specific behavioral issues for which the drug was used, which assist in monitoring the drug's effectiveness. During interview at 11:00 AM on 3/30/11, the Psychiatric NP (Nurse Practitioner) to whom Resident #76 had been referred for consult, stated that the resident had received Seroquel to help manage behaviors related to a specific diagnosis, which was different from the specific behaviors the resident exhibited for which s/he received an antianxiety drug. The Unit Charge Nurse confirmed, during interview at 3:40 PM on 3/30/11, that the care plan lacked the name of the antipsychotic drug, and lacked objectives and specific targeted behaviors for the use of the drug. 2. Per record review, Resident #27 did not have a care plan addressing Dental Care. The family interview on 3/28/2011 at 1:22 PM revealed that the resident's lower dentures were lost while in the facility. A dental consult was conducted on 4/13/2010 and the report states that the resident had one lower tooth (number 22) which was broken and sharp and the tooth was filed down almost to the gum line. The only remaining lower	F 279	F279 continued from page 1 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Residents that are on psychotropic medications will have separate care plan sheet with specific behaviors and measurable goals. All residents that have dental concerns will have care plans for their dental needs. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** On admission, upon significant change in resident status and as residents come due for their next Minimum Data Set (MDS) assessment, resident's care plans will be reviewed to ensure the care plans continue to accurately reflect the resident's status and have measureable goals and timely goal dates. All nursing staff will attend an in-service. The in-service will be conducted by the Director of Nursing or designee. The in-service will cover: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Care plan development and updates • Goals including measurable goals-dates • Revision and updating of care plans as needed	5/13/11 5/13/11 4/12/11

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F 279	Continued From page 2 tooth was tooth #27. The dentist recommendation was for a mechanical soft diet since there was only one remaining tooth in the lower jaw to bite against. On 4/26/2010, a faxed request was sent to the physician and approved for a house diet with finely chopped meats per resident and family request. In a record review on 3/30/2011 there is no dental care plan for this resident nor are dental needs and concerns addressed in the nutrition, ADL, or other sections of the care plan. The Unit Manager confirmed in an interview at 10:25 AM on 3/30/2011 that there was no care plan addressing dental needs for this resident.	F 279	F279 continued from page 2 **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nursing (DON) or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance. The audits will be conducted weekly for a month, then monthly for one quarter and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the need for further monitoring. F279 POC Accepted 5/23/11 CMcLeRN	4/18/11
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F 280** The Facility has and continues to ensure that the care plans are developed/revised and/or reviewed as needed and that residents can participate in their plan of care. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The resident's falls will be documented on the resident's care plan. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents at risks for falls have the potential to be affected by this practice. Nursing staff will comply with Policy and Procedure and update care plan with each resident's fall.	4/12/11 5/06/11

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to assure the comprehensive care plan was revised to reflect the current status of 1 of 15 residents in the applicable sample. (Resident # 76) Findings include: Per record review, the care plan for Resident #76 had not been revised to reflect current status following a recent fall, and in accordance with the facility's Policy and Procedure, titled: Falls Risk Assessment, dated 10/27/09. The resident's care plan, dated 1/20/11, reflected that the resident had a history of falls, was at risk for further falls, and identified the goal as: "Will have no fall resulting in injury in the next 90 days". A nurse's note, dated 3/18/11 at 9:15 PM, stated the resident was "found on the floor at 5:00 PM...no injury noted...". Although the facility's policy states, under Policy Interpretation and Implementation; #5. "The care plan will be reviewed and revised by the charge nurse after each fall", there was no evidence that the care plan had been updated with the resident fall status or that new goals or interventions had been considered and/or implemented following that fall. The Quality Nurse who oversees the Falls Committee agreed, during interview at 1:55 PM on 3/30/11, that the care plan did not include any dated entries to indicate any revision following the resident's fall on 3/18/11.	F 280	F280 continued from page 3 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Licensed nurses will be educated on the importance of following the policy and procedure pertaining to falls and all steps to be followed. Education will be provided on care plan compliance at an in-service for all nursing staff and will be reviewed at the RN/LPN meeting. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff and that the plan of care is being followed. The audits will be conducted weekly for one month, and then bi-monthly for 3 months until 100% compliance is obtained. The DON or designee will report the results of the audits to the Quality Assurance committee which will determine the need for further monitoring. F280 POC Accepted 5/23/11 DMcotaRN **F282** The facility has and continues to ensure that services provided or arranged by qualified persons in accordance with each resident's written plan of care. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Falling star symbols have been placed on resident #76 and resident #50 doorways per their care plans for being at risk for falls.	5/06/11 5/03/11 3/31/11
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 4 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide services in accordance with the individual plan of care for 2 of 15 residents in the applicable sample. (Residents #50 and #76). Findings include: Per observation, there was no Falling Star symbol placed on the doorway of either Resident #50 or #76 as indicated in their respective care plans. Resident #50 and Resident #76 were each identified as at risk for falls and each had a care plan, dated 10/28/10 and 1/20/11, respectively, that identified fall prevention interventions which included; "place Falling Star on doorway and chart indicating falls risk." Per observation, on the afternoon of 3/30/11, the Quality Nurse confirmed the lack of a Falling Star on the doorway of Resident #76's room. The lack of presence of a Falling Star on the doorway to Resident #50's room was confirmed by the Unit Charge Nurse during interview at 3:40 PM on the afternoon of 3/30/11.	F 282	F282 continued from page 4 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential for the Falling stars symbols to be missing from their doors. All residents assessed to be at risk for falls will have their doorways checked for a falling star symbol. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and;** Residents that are at risk for falls will have a Falling star symbol on their door in an area that they are unable to reach, therefore, the care plan will be followed and the residents will be unable to remove the item. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The residents that are fall risks will have their doorway audited to assure the falling star symbol is in place and the care plan is being followed. The audits will be conducted weekly for one month, then monthly for one quarter and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the need for further monitoring. F282 POC Accepted 5/23/11 AM Mot RN	3/31/11 4/18/11 4/18/11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	**F371** The facility has and continues to ensure the procurement, storage, preparation, distribution and service of food is under sanitary conditions.	

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F 371	Continued From page 5 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure safe food storage in one resident nourishment refrigerator and in one kitchen located on a resident unit. Findings include: 1. During the initial tour of the facility on 3/28/11 at 11:55 AM, the resident nourishment refrigerator on B Wing was discovered to contain: 1 product in a covered container labeled with a name and dated 3/18/11; 1 unlabeled/undated food item in a dish which was covered with clear wrap; and 1 clear plastic bag of Brussels sprouts with no label or date. During an interview on 3/28/11 at 11:57 AM, the nurse manager of the B wing unit confirmed the presence of 2 unlabeled/undated items and 1 item dated 3/18/11 in the unit's resident nourishment refrigerator. During an interview on 3/30/11 at 11:15 AM, the Director of Hospitality Services (who supervises the Food Services Director) confirmed that the food items which were unlabeled, undated, and/or dated 3/18/11 were not consistent with the facility's expectation that stored foods would be monitored and removed from the snack refrigerators daily. No written policy regarding monitoring and discarding of stored foods was provided by the facility. 2. During a tour of the facility on the morning of 3/28/11, the following observations were made in	F 371	F371 continued from page 5 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** 1. Food item in the B-wing refrigerator was disposed of. 3/28/11 2. Personal hygiene products were removed and relocated to a shelf not adjacent to resident food products. 3/31/11 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this practice. 1. Outdated food item has been disposed of. 3/28/11 2. Personal hygiene products were removed and relocated to a shelf not adjacent to resident food products. 3/31/11 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** An in service will be provided to staff on general food safety, 5/13/11 1., 2. The following will be completed in the residents' unit food refrigerators and clean service areas: • Posting of FDA based guidelines for how long a particular food item may be safely stored. • Provision of labels to clearly indicate the expiration date of the food item • A documented, daily audit of food items that insures items are properly labeled & stored, and discarded immediately after the listed expiration dates. • This audit will include checking that no cross-contamination or potential exists in the refrigerators or clean-service areas.	

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F 371	Continued From page 6 the kitchen located on the A and C Wings Unit: personal hygiene product supplies including; plastic bottles of Body Wash, Peri Wash and one small plastic bottle containing 4 oz of enema solution were stored in a cabinet with the doors open, and directly above a microwave and open plastic basin containing multiple packages of individually wrapped crackers and cookies identified by the Charge Nurse as being for resident consumption. The Charge Nurse confirmed the storage of personal hygiene product supplies directly above food targeted for resident consumption, at the time of tour. During interview, at 9:20 AM on the morning of 3/30/11, the DNS (Director of Nursing Services) stated that resident personal hygiene supplies should not be stored in the kitchen area.	F 371	F371 continued from page 6 • The audit results will be reviewed daily at each unit's Team QA Meeting. • Completed audit documents will be kept for 90 days. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The daily audits sheets and the residents' food storage areas will be monitored by the Director of Hospitality Services or designee to ensure continued compliance of staff in assuring the proper storage of the food and personal hygiene items are under sanitary conditions. The monitoring will be conducted weekly for 3 months and until 100% compliance is obtained. The Director of Hospitality Services or designee will report the results of the audits to the Quality Assurance committee which will determine the need for further monitoring.	05/03/11
F9999	FINAL OBSERVATIONS Per Vermont Licensing and Operating Rules for Nursing Homes December 15, 2001, 3.17 d) (3) (e), "A facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aid or other facility staff to the Vermont State Nurse Assistants Registry or the appropriate licensing authority and the licensing agency. Actions by a court of law which indicate unfitness for service include a charge of abuse, neglect, or exploitation substantiated against an employee or conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction within or outside the State of Vermont". (h)"The results of all investigation must be reported to the administrator or his or her designated representative and to the licensing agency in accordance with 33 V. S. A. Chapter	F9999	F371 POC Accepted 5/23/11 DMastaRN **F9999** The Facility has and continues to ensure that it continues to report to appropriate State of Vermont Agencies any known actions by a court of law which indicate a staff member is unfit for service including a charge of abuse, neglect, or exploitation substantiated against an employee or conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The facility requested an employment waiver for the employee identified with a misdemeanor conviction.	3/30/11

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F9999	Continued From page 7 69, and if the alleged violation is verified, appropriate corrective action must be taken." This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility retained one employee whose Vermont Criminal Information Center (VCIC) background check revealed a criminal conviction. Findings include: During record review at 9:00 AM on 3/30/11, the VCIC background check for one of five employees in the sample revealed a misdemeanor conviction. During an interview on 3/30/11 at 9:25 AM, the Human Resources Director confirmed that the facility had not requested and could not produce a waiver to retain this employee.	F9999	F 9999 continued from page 7 The facility received the employment waiver for the individual identified with the misdemeanor conviction from the State of Vermont's Division of Licensing and Protection. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All employee background checks to be reviewed by the Director of Human Resources if any employees with a criminal conviction are found without a current employment waiver an employment waiver will be sought from the State of Vermont's Division of Licensing and Protection. Any employee with an identified criminal conviction will be notified of the request for the waiver and the potential implication of continued employment at the facility. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All individual applicants for employments that are given an offer of employment will have a criminal background check completed. Any findings of a criminal conviction from the Vermont Criminal Information Center will result in the facility rescinding an offer of employment or seeking an employment waiver from the State of Vermont's Division of Licensing and Protection.	4/06/11 5/20/11

F9999 continued from page 8

A record of new employees will be maintained by the Director of Human Resources listing the date of the criminal background check request, criminal background check receipt, any criminal conviction, waiver request, receipt of waiver and first day of employment. 4/22/11

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

The new employment hires record will be maintained for 3 months and until 100% compliance with request for employment waivers is achieved. This record will be reviewed weekly by the Administrator and monitored by a report to the Quality Assurance Committee. 5/03/11

F9999 POC Accepted 5/23/11 PMcotaRN